

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9195
CERTIFICATE OF DEATH

09163

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kennedyville (Locust Grove 10 YRS)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kennedyville, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				d. STREET ADDRESS _____		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HOPE CALDWELL COPPER</u>				4. DATE OF DEATH Month <u>August</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 8, 1876</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>JOHN FRANK COPPER</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN WATTS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-12-40348</u>		17. INFORMANT Address <u>Mrs. Mildred Cleaver Kennedyville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Urinary Tract infection, with Uremia</u> <u>610X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prostatism</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardiovascular disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month _____ Day _____ Year <u>1959</u> Hour _____ o. m. _____ p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1</u> , 19 <u>59</u> , to <u>August 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>August 6</u> , 19 <u>59</u> , and that death occurred at <u>5:00A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chestertown Md.</u> DATE SIGNED <u>6 August 1959</u>							
ACTUAL SIGNATURE <u>R. W. Farr</u> M.D.				PHYSICIAN'S NAME (Type) <u>Rocert W. Farr</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-9-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CHURCH HILL CEMT Y</u>		22d. LOCATION (City, town, or county) (State) <u>CHURCH HILL MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor H. Kennedy</u>				ADDRESS <u>STILL POND, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 7 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>				24c. REGISTRAR'S NAME <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

010103

CERTIFICATE OF DEATH

010103

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 12-5-29		5. PLACE OF BIRTH MOBILE, ALA.	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. COLOR White		9. HEIGHT 5' 10"		10. WEIGHT 175	
11. CAUSE OF DEATH Suicide		12. MANNER OF DEATH Homicide		13. PLACE OF DEATH Baltimore, Md.		14. DATE OF DEATH 4-4-68		15. TIME OF DEATH 11:00 AM	
16. SIGNATURE OF DECEASED James Earl Ray		17. SIGNATURE OF NEXT OF KIN John Howard Ray		18. SIGNATURE OF PHYSICIAN Dr. J. Edgar Hoover		19. SIGNATURE OF CORONER Dr. J. Edgar Hoover		20. SIGNATURE OF JURY Dr. J. Edgar Hoover	
21. SIGNATURE OF DECEASED James Earl Ray		22. SIGNATURE OF NEXT OF KIN John Howard Ray		23. SIGNATURE OF PHYSICIAN Dr. J. Edgar Hoover		24. SIGNATURE OF CORONER Dr. J. Edgar Hoover		25. SIGNATURE OF JURY Dr. J. Edgar Hoover	
26. SIGNATURE OF DECEASED James Earl Ray		27. SIGNATURE OF NEXT OF KIN John Howard Ray		28. SIGNATURE OF PHYSICIAN Dr. J. Edgar Hoover		29. SIGNATURE OF CORONER Dr. J. Edgar Hoover		30. SIGNATURE OF JURY Dr. J. Edgar Hoover	
31. SIGNATURE OF DECEASED James Earl Ray		32. SIGNATURE OF NEXT OF KIN John Howard Ray		33. SIGNATURE OF PHYSICIAN Dr. J. Edgar Hoover		34. SIGNATURE OF CORONER Dr. J. Edgar Hoover		35. SIGNATURE OF JURY Dr. J. Edgar Hoover	
36. SIGNATURE OF DECEASED James Earl Ray		37. SIGNATURE OF NEXT OF KIN John Howard Ray		38. SIGNATURE OF PHYSICIAN Dr. J. Edgar Hoover		39. SIGNATURE OF CORONER Dr. J. Edgar Hoover		40. SIGNATURE OF JURY Dr. J. Edgar Hoover	
41. SIGNATURE OF DECEASED James Earl Ray		42. SIGNATURE OF NEXT OF KIN John Howard Ray		43. SIGNATURE OF PHYSICIAN Dr. J. Edgar Hoover		44. SIGNATURE OF CORONER Dr. J. Edgar Hoover		45. SIGNATURE OF JURY Dr. J. Edgar Hoover	
46. SIGNATURE OF DECEASED James Earl Ray		47. SIGNATURE OF NEXT OF KIN John Howard Ray		48. SIGNATURE OF PHYSICIAN Dr. J. Edgar Hoover		49. SIGNATURE OF CORONER Dr. J. Edgar Hoover		50. SIGNATURE OF JURY Dr. J. Edgar Hoover	
51. SIGNATURE OF DECEASED James Earl Ray		52. SIGNATURE OF NEXT OF KIN John Howard Ray		53. SIGNATURE OF PHYSICIAN Dr. J. Edgar Hoover		54. SIGNATURE OF CORONER Dr. J. Edgar Hoover		55. SIGNATURE OF JURY Dr. J. Edgar Hoover	
56. SIGNATURE OF DECEASED James Earl Ray		57. SIGNATURE OF NEXT OF KIN John Howard Ray		58. SIGNATURE OF PHYSICIAN Dr. J. Edgar Hoover		59. SIGNATURE OF CORONER Dr. J. Edgar Hoover		60. SIGNATURE OF JURY Dr. J. Edgar Hoover	
61. SIGNATURE OF DECEASED James Earl Ray		62. SIGNATURE OF NEXT OF KIN John Howard Ray		63. SIGNATURE OF PHYSICIAN Dr. J. Edgar Hoover		64. SIGNATURE OF CORONER Dr. J. Edgar Hoover		65. SIGNATURE OF JURY Dr. J. Edgar Hoover	
66. SIGNATURE OF DECEASED James Earl Ray		67. SIGNATURE OF NEXT OF KIN John Howard Ray		68. SIGNATURE OF PHYSICIAN Dr. J. Edgar Hoover		69. SIGNATURE OF CORONER Dr. J. Edgar Hoover		70. SIGNATURE OF JURY Dr. J. Edgar Hoover	
71. SIGNATURE OF DECEASED James Earl Ray		72. SIGNATURE OF NEXT OF KIN John Howard Ray		73. SIGNATURE OF PHYSICIAN Dr. J. Edgar Hoover		74. SIGNATURE OF CORONER Dr. J. Edgar Hoover		75. SIGNATURE OF JURY Dr. J. Edgar Hoover	
76. SIGNATURE OF DECEASED James Earl Ray		77. SIGNATURE OF NEXT OF KIN John Howard Ray		78. SIGNATURE OF PHYSICIAN Dr. J. Edgar Hoover		79. SIGNATURE OF CORONER Dr. J. Edgar Hoover		80. SIGNATURE OF JURY Dr. J. Edgar Hoover	
81. SIGNATURE OF DECEASED James Earl Ray		82. SIGNATURE OF NEXT OF KIN John Howard Ray		83. SIGNATURE OF PHYSICIAN Dr. J. Edgar Hoover		84. SIGNATURE OF CORONER Dr. J. Edgar Hoover		85. SIGNATURE OF JURY Dr. J. Edgar Hoover	
86. SIGNATURE OF DECEASED James Earl Ray		87. SIGNATURE OF NEXT OF KIN John Howard Ray		88. SIGNATURE OF PHYSICIAN Dr. J. Edgar Hoover		89. SIGNATURE OF CORONER Dr. J. Edgar Hoover		90. SIGNATURE OF JURY Dr. J. Edgar Hoover	
91. SIGNATURE OF DECEASED James Earl Ray		92. SIGNATURE OF NEXT OF KIN John Howard Ray		93. SIGNATURE OF PHYSICIAN Dr. J. Edgar Hoover		94. SIGNATURE OF CORONER Dr. J. Edgar Hoover		95. SIGNATURE OF JURY Dr. J. Edgar Hoover	
96. SIGNATURE OF DECEASED James Earl Ray		97. SIGNATURE OF NEXT OF KIN John Howard Ray		98. SIGNATURE OF PHYSICIAN Dr. J. Edgar Hoover		99. SIGNATURE OF CORONER Dr. J. Edgar Hoover		100. SIGNATURE OF JURY Dr. J. Edgar Hoover	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9196 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09164

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Kent <div style="text-align: right;">MARYLAND</div>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake Bay near Rock Hall, Md.		c. LENGTH OF STAY IN 1b nr. Rock Hall		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS Piney Neck		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) James Lemuel Crouch			4. DATE OF DEATH Aug. 23, 1959		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 9, 1932		9. AGE (In years last birthday) 27 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrical Contractor self employed		10b. KIND OF BUSINESS OR INDUSTRY Kent Co. Maryland		10c. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME G. Cecil Crouch			14. MOTHER'S MAIDEN NAME Helen Wood		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-30-8415		17. INFORMANT Mrs. Helen W. Crouch Address Rock Hall, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning 850x DUE TO Fell over board from boat in waters of the Chesapeake Bay near Rock Hall Md. at about 10:30 A.M. 8/23/59. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Body was recovered in same area about 8:00 A.M. 8/26 (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Instantaneous					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 0:30 Hour 8/23 a. m. 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Chesapeake Bay Rock Hall Kent Md.	
20f. (City or town) Rock Hall		20g. (County) Kent		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Robert W. Farr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/27 /59	
EXAMINER'S NAME (Type) Robert W. Farr		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/27/59		22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem.	
22d. LOCATION (City, town, or county) Rock Hall, Md.		22e. (State) Md.		22f. (County) Kent	
23. FUNERAL DIRECTOR'S SIGNATURE G. Wills Wells		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR AUG 28 '59	
24b. REGISTRAR'S SIGNATURE G. Wills Wells					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

9197

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09165

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Worton RFD		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) Coleman's Corner		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Linnington Middle Dorsey Last Dorsey		4. DATE OF DEATH Month Aug. Day 4 Year 1959	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/6/05
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months 54 Days 54 Hours 54 Min. 54	IF UNDER 24 HRS. Months 54 Days 54 Hours 54 Min. 54
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY Kent Co. Md.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Armor Dorsey		14. MOTHER'S MAIDEN NAME Beulah Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 222-03-1349	
17. INFORMANT Beulah Jackson Worton, Md. Rfd		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation 444X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Auricular Fibrillation (c) Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Occlusion April 1959			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5 min. 2 years 2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 5, 1958 to August 4, 1959 , that I last saw the deceased alive on August 14, 1959 , and that death occurred at 8 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Worton, Md. DATE SIGNED ACTUAL SIGNATURE Florence D. Joyce M.D. Worton, Md. PHYSICIAN'S NAME (Type) Florence D. Joyce Worton, Md. RFD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/9/59	
22c. NAME OF CEMETERY OR CREMATORY Coleman's Cemetery		22d. LOCATION (City, town, or county) (State) Worton, Md. RFD	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Waller		24a. REC'D BY REGISTRAR DATE AUG 10 '59	
ADDRESS Chestertown, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09166

9198

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Locust Grove		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Locust Grove, Rural Kennedyville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HARRY Middle R. Last GARY		4. DATE OF DEATH Month August Day 25 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July, 11, 1868
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mason		10b. KIND OF BUSINESS OR INDUSTRY Brick Work	
11. BIRTHPLACE (State or foreign country) Del.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James H. Gary		14. MOTHER'S MAIDEN NAME Mary V. Price	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-24-1026	
17. INFORMANT Mrs. Della Bickling, Chestertown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of Lip & Throat DUE TO (c) Heart INTERVAL BETWEEN ONSET AND DEATH 4 1/2 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 50 , to August , 19 59 , that I last saw the deceased alive on Aug 25 , 19 59 , and that death occurred at 8 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE L. P. Atwell		ADDRESS (Street, city or town, state) Still Pond Md.	
DATE SIGNED M.D.			
PHYSICIAN'S NAME (Type) Dr. L.P. Atwell		Still Pond, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 28, 1959	
22c. NAME OF CEMETERY OR CREMATORY Galena Cemetery		22d. LOCATION (City, town, or county) (State) Galena, Kent Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows, Dellington, Md		24a. REC'D BY REGISTRAR DATE AUG 31 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9192
CERTIFICATE OF DEATH

09167

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hospital (1 day)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Grover Middle C. Last Hadaway		4. DATE OF DEATH Month Aug. Day 22 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/8/34
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 7 Days 4 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Meat Cutter (etail)		11. BIRTHPLACE (State or foreign country) Kent Co. Maryland	
12. CITIZEN OF WHAT COUNTRY? Usa		13. FATHER'S NAME Thomas B. Hadaway	
14. MOTHER'S MAIDEN NAME Mary Brown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. 217-20-3176		17. INFORMANT Mrs. Murial Hadaway Address Mill St. Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 8 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/22 , 19 59 , to 8/22 , 19 59 , that I last saw the deceased alive on 8/22 , 19 59 , and that death occurred at 6:20 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 8/24/59 ACTUAL SIGNATURE Robert W. Farr M.D. PHYSICIAN'S NAME (Type) Robert W. Farr M. D. Chestertown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/25/59	
22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE AUG 26 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

1
 This is to certify that the within and foregoing is a true and correct copy of the original as the same appears in the files of the Department of Health and Mental Hygiene of the State of Maryland.
 Witness my hand and the seal of the Department of Health and Mental Hygiene at Annapolis, Maryland, this 1st day of May, 1934.

MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
 CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 12/15/1888		5. PLACE OF BIRTH Baltimore, Md.		6. OCCUPATION Clerk	
7. MARITAL STATUS Married		8. COLOR White		9. HEIGHT 5' 8"		10. WEIGHT 150 lbs.		11. BUILD Medium		12. COMPLEXION Fair	
13. EDUCATION High School		14. RELIGION Catholic		15. PRESENT ADDRESS 1234 Elm St., Baltimore, Md.		16. PREVIOUS ADDRESS 5678 Oak St., Baltimore, Md.		17. DATE OF DEATH 4/28/34		18. PLACE OF DEATH Home	
19. CAUSE OF DEATH Coronary thrombosis		20. MANNER OF DEATH Natural		21. TIME OF DEATH 10:30 A.M.		22. SIGNATURE OF PHYSICIAN J. H. Smith		23. SIGNATURE OF WITNESSES J. H. Smith, J. D. Jones		24. SIGNATURE OF DECEASED J. H. Harris	
25. NAME OF FUNERAL HOME J. H. Harris & Co.		26. ADDRESS OF FUNERAL HOME 1234 Elm St., Baltimore, Md.		27. DATE OF BURIAL 5/1/34		28. PLACE OF BURIAL St. Mary's Cemetery		29. NAME OF MINISTER Rev. J. H. Smith		30. ADDRESS OF MINISTER 5678 Oak St., Baltimore, Md.	

9193

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Queen Anne's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne's Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevensville			
				d. STREET ADDRESS 17X-2			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First William Middle Lee Last Hope				4. DATE OF DEATH Month 8 Day 24 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/17/81	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? America							
13. FATHER'S NAME Lee Hope				14. MOTHER'S MAIDEN NAME Lula ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Son, William Hope, Fred	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 33/X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month 8 Day 23 Year 1959 Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) Rock Hall		(County) (State)	
21. I certify that I attended the deceased from 8/23 , 19 59 , to 8/24 , 19 59 , that I last saw the deceased alive on 8/23 , 19 59 , and that death occurred at 4 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rock Hall DATE SIGNED 8/24/59 ACTUAL SIGNATURE William M. Hestwood M.D. PHYSICIAN'S NAME (Type) William M. Hestwood							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/27/59		22c. NAME OF CEMETERY OR CREMATORY Kings Mountain		22d. LOCATION (City, town, or county) (State) Kings Mountain NC	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Sore				24a. REC'D BY REGISTRAR Chuck Hill MD		24b. REGISTRAR'S SIGNATURE Charles L. Kneib	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9199

CERTIFICATE OF DEATH

09169

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Kent</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Betterton In Car</u> LENGTH OF STAY (in this place) <u>Short</u> TOWN <u>Betterton</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Kent</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>37 Chestertown (Lifetime)</u> OR TOWN <u>Chestertown</u> STREET ADDRESS (If rural give location) <u>High St.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Etta</u> <u>Cooper</u> <u>Robinson</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 30, 1959</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 5, 1888</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Kent Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel E. Cooper</u>				14. MOTHER'S MAIDEN NAME <u>Margaret A. Patrick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS <u>Mrs. Hallie Simpson</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> IMMEDIATE CAUSE (A) <u>VENTRICULAR FIBRILATION</u>						<u>5 Minutes</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic left sided coronary insufficiency</u>						<u>3 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>antero-lateral myocardial infarct</u>						<u>3 years</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 19 <u>55</u> , to <u>August</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>August 21, 1959</u> , and that death occurred at <u>4:45</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Florence D. Joyce</u>				ADDRESS (Street, city, town, state) <u>Md. Chestertown</u>			
DATE SIGNED <u>8/30/59</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Sept. 2, 1959</u>		NAME OF CEMETERY OR CREMATORY <u>Chester Cem.</u>		LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>SEP 1 '59</u>		REGISTRAR'S SIGNATURE <u>Christine E. Frank</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John Willis Wells</u> ADDRESS <u>Chestertown</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9200

CERTIFICATE OF DEATH

09170

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown RURAL</u>		c. LENGTH OF STAY IN 1b <u>RFD</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Chestertown RFD</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Albert</u> First <u>Scott</u> Middle <u>Lost</u> Last		4. DATE OF DEATH Month <u>Aug.</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1876</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Lula Scott</u>		Address <u>Chestertown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senility</u> <u>794X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>One month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 8</u> , 19 <u>59</u> , to <u>Aug 7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Aug 6</u> , 19 <u>59</u> , and that death occurred at <u>2 a. m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Rock Hall, Md.</u> DATE SIGNED <u>8/17/59</u>			
ACTUAL SIGNATURE <u>Eugene Kester</u>		M.D. <u>O. Kester</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/19/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Georgetown Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>near - Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Coley</u>		ADDRESS <u>Chestertown, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

CERTIFICATE OF DEATH

0290

<p>1. NAME OF DECEASED [Faint text, possibly "John Doe"]</p>		<p>2. SEX [Faint text, possibly "Male"]</p>	
<p>3. AGE [Faint text, possibly "45 years"]</p>		<p>4. DATE OF BIRTH [Faint text, possibly "1880-01-01"]</p>	
<p>5. PLACE OF BIRTH [Faint text, possibly "Boston, Mass."]</p>		<p>6. OCCUPATION [Faint text, possibly "Teacher"]</p>	
<p>7. CAUSE OF DEATH [Faint text, possibly "Heart disease"]</p>		<p>8. MANNER OF DEATH [Faint text, possibly "Natural"]</p>	
<p>9. DATE OF DEATH [Faint text, possibly "1920-03-15"]</p>		<p>10. PLACE OF DEATH [Faint text, possibly "Home"]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Faint signature]</p>		<p>12. SIGNATURE OF REGISTRAR [Faint signature]</p>	
<p>13. NAME OF PHYSICIAN [Faint text, possibly "Dr. John Smith"]</p>		<p>14. NAME OF REGISTRAR [Faint text, possibly "John Doe"]</p>	
<p>15. ADDRESS OF PHYSICIAN [Faint text, possibly "123 Main St, Boston, Mass."]</p>		<p>16. ADDRESS OF REGISTRAR [Faint text, possibly "City Hall, Boston, Mass."]</p>	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 18

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

VS. A15ME
SM 2/57

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FOR STATE
HEALTH DEPT.



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9201

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09171

1. PLACE OF DEATH a. COUNTY KENT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WORTON (RURAL)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Worton, Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Andelot Farm		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANNAE LOUISE THORNTON		4. DATE OF DEATH Month Aug Day 3 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 24, 1887
9. AGE (in years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	
11. IF UNDER 24 HRS. Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? U.S.A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Alonzo Boulden		14. MOTHER'S MAIDEN NAME Rosa Simpson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never unknown) No		16. SOCIAL SECURITY NO. 222-20-2070	
17. INFORMANT Eugene Thornton, Worton, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable acute pulmonary edema 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acute coronary insufficiency - 3-4 weeks DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arterial hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Had body's clothes for 8 to 10 yrs. On apparent good health until 1 week before death. Sudden death.	
20c. TIME OF INJURY Month, Day, Year Hour 10 AM		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> shortness of breath, pain in chest, nausea & died 1 1/2 hours later	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at 245 Am.		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Robert W Farr M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) ROBERT W. FARR		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 8/3/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 5/59	
22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Chesapeake City - Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin K. Williams - Chesapeake Md.		24a. REC'D BY REGISTRAR AUG 5 '59	
24b. REGISTRAR'S SIGNATURE Carlton L. Harris			

DECEASED
Name: WILLIAM J. KENT
Age: 45
Sex: Male
Race: White
Date of Birth: 1910
Place of Birth: Washington, D.C.
Usual Residence: 1234 Main St., Baltimore, Md.
Cause of Death: Heart Disease
Manner of Death: Natural
Signature of Examiner: [Signature]
Date: 10/10/37

1. I, the undersigned, being a duly qualified Medical Examiner, do hereby certify that the above is a true and correct statement of the facts as to the cause and manner of death of the deceased.

2. I further certify that the deceased was at the time of death a resident of the State of Maryland.

3. I further certify that the deceased was at the time of death a citizen of the United States.

4. I further certify that the deceased was at the time of death a resident of the City of Baltimore.

5. I further certify that the deceased was at the time of death a resident of the County of Baltimore.

6. I further certify that the deceased was at the time of death a resident of the State of Maryland.

7. I further certify that the deceased was at the time of death a citizen of the United States.

8. I further certify that the deceased was at the time of death a resident of the City of Baltimore.

9. I further certify that the deceased was at the time of death a resident of the County of Baltimore.

10. I further certify that the deceased was at the time of death a resident of the State of Maryland.

9194

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09172

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent & Queen Anne Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Minta Vickers</u>				4. DATE OF DEATH Month Day Year <u>Aug. 4, 1959</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/19/80</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Startt</u>				14. MOTHER'S MAIDEN NAME <u>Copper Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>Hospital Records</u>			
17. INFORMANT <u>Hospital Records</u>				Address <u>Chestertown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shunt Myocardial Revascularization</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Heart Disease</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>8/4/59 1000 AM</u> to <u>8/4/59 2:00 PM</u> , that I last saw the deceased alive on <u>8/4/59 2 PM</u> , 19 <u>59</u> , and that death occurred at <u>2:46 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William M. Gatewood</u> M.D.				ADDRESS (Street, city or town, State) <u>Rock Hall, Md.</u>			
PHYSICIAN'S NAME (Type) <u>William M. Gatewood</u>				DATE SIGNED <u>8/6/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/7/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. William Wells</u>				ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 10 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

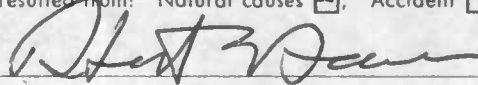

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09173

9202

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Millington		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First JOHN Middle LEE Last WARNER				4. DATE OF DEATH Month August Day 9 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan. 30, 1927	9. AGE (In years last birthday) 32 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles E. Warner				14. MOTHER'S MAIDEN NAME Iola J. Pratt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 2		17. INFORMANT Address Charles E. Warner (Father) Millington, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Convulsive seizure DUE TO Probable Chronic Brain Syndrome Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Alcoholism DUE TO Tumor left temporal lobe (c) Had been on an alcoholic binge for about a week. In the past 4 or 5 years, had been subject to generalized seizures when drinking. In the past 4 or 5 years, had been subject to generalized seizures when drinking. Was apparently well when left alone at about 10:30 AM. Was found dead, face down on the floor, at 5:30 PM. Blood present appeared to have come from injury to tongue.				INTERVAL BETWEEN ONSET AND DEATH short several years several years			
20a. PRIMARY CAUSE OF DEATH PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) Robert W. Farr				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED August 9, 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF AUG. 12, 1959		22c. NAME OF CEMETERY OR CREMATORY SUDLERSVILLE CEM.		22d. LOCATION (City, town, or county) (State) SUDLERSVILLE MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Hollows				24a. REC'D BY REGISTRAR DATE AUG 14 '59		24b. REGISTRAR'S SIGNATURE 	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

NAME OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

RELIGION

OCCUPATION

PREVIOUS ILLNESS

DATE OF EXAMINATION

EXAMINER'S SIGNATURE

DATE OF REPORT

REPORTING OFFICE

REPORTING OFFICER

REPORTING OFFICER'S SIGNATURE

REPORTING OFFICER'S TITLE

REPORTING OFFICER'S ADDRESS

REPORTING OFFICER'S PHONE

REPORTING OFFICER'S FAX

REPORTING OFFICER'S E-MAIL

REPORTING OFFICER'S WEBSITE

REPORTING OFFICER'S SOCIAL MEDIA

REPORTING OFFICER'S OTHER CONTACT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9203 CERTIFICATE OF DEATH

09174

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Still Pond</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>at home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>White</u> Last <u>White</u>		4. DATE OF DEATH <u>8/5/59</u> Month <u>8</u> Day <u>5</u> Year <u>19</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 26, 1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer at general store</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas A. White</u>		14. MOTHER'S MAIDEN NAME <u>Carrie A. Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>17-12-4902</u>	
17. INFORMANT <u>Mary White</u>		Address <u>Still Pond, Md. Box # 49</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Liver</u> <u>156.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Endocarditis</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ribbed</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>no</u> 19 p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Aug 7 Kent Md.</u> (County) (State)	
21. I certify that I attended the deceased from <u>May 30, 1959</u> to <u>Aug 5 1959</u> , that I last saw the deceased alive on <u>Aug 5, 1959</u> , and that death occurred at <u>Aug 5, 1959</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. P. Atwell</u>		M.D. <u>Still Pond, Md.</u> DATE SIGNED <u>8/6/59</u>	
PHYSICIAN'S NAME (Type) <u>L. P. Atwell</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/8/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Still Pond Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Still Pond, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth Walby</u>		ADDRESS <u>Mt. Zion Chestertown, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>	

